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107 Waiver Services

Medicaid covers Home and Community-Based Services (HCBS) through the Elderly and Disabled (E&D) Waiver, the State of Alabama Independent Living (SAIL) Waiver (formerly Homebound Waiver), the Technology Assisted (TA) Waiver for Adults and the HIV/AIDS Waiver to categorically needy individuals who would otherwise require institutionalization in a nursing facility.

Medicaid covers the Alabama Home and Community-Based Waiver for Persons with Mental Retardation(MR Waiver),formerly MR/DD and the Living at Home (LHW) Waiver to Medicaid-eligible individuals who would otherwise require the level of care available in an intermediate care facility for the mentally retarded (ICF-MR).

The purpose of providing HCBS to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as a waiver service. HCBS are provided through a Medicaid waiver for an initial period of three years and for five-year periods thereafter upon renewal of waiver by the Centers for Medicare and Medicaid Services (CMS) .

The E&D Waiver is a cooperative effort among the Alabama Medicaid Agency, Alabama Department of Public Health (ADPH), and the Alabama Department of Senior Services (ADSS). The policy provisions for E&D Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 36.

The SAIL Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama-Department of Rehabilitation Services (ADRS). The policy provisions for SAIL Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 57.

The MR and LHW Waivers are a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation (DMH/MR). The policy provisions for MR and LHW Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapters 35 and 52 respectively.

The Technology Assisted (TA) Waiver for Adults serves individuals who received private duty nursing services through the EPSDT Program under the Alabama Medicaid State Plan who will no longer be eligible for this service upon turning age 21, and for whom private duty nursing continues to be medically necessary based upon approved private duty nursing criteria. The Alabama Medicaid Agency is the Operating Agency for the TA Waiver for Adults. The policy provisions for providers of the TA Waiver for Adults can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 54.

NOTE:

Providers rendering private duty nursing services as a result of an EPSDT screening should refer to the Alabama Medicaid Provider Manual, Chapter 31 for policy provisions.

The HIV/AIDS Waiver is a cooperative effort among the Alabama Medicaid Agency and the Alabama Department of Public Health (ADPH). The policy provisions for HIV/AIDS Waiver providers can be found in the Alabama Medicaid Agency Administrative Code, Chapter 58.

107.1 Enrollment

Applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual* should apply with the designated waiver Operating Agency for the E&D, SAIL, MR, Living at Home and HIV/AIDS Waivers. Applicants for the TA Waiver are enrolled directly through EDS.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contract with Alabama Medicaid as a waiver provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive direct reimbursement for waiver-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Providers of waiver services are assigned a provider type of 53 (Waiver Service). Valid specialties for these providers include the following:

- Elderly and Disabled Waiver (670)
- SAIL Waiver (660)
- MR Waiver (680)
- Living at Home Waiver (690)
- Technology Assisted (TA) Waiver for Adults (590)
- HIV/AIDS Waiver (620)

Enrollment Policy for Waiver Service Providers

To participate in the Alabama Medicaid Program, providers must meet the following requirements:

- Must have a contractual agreement with Medicaid directly or through an Operating Agency
- Must meet the provider qualifications as outlined in the approved Waiver Document for the appropriate HCBS waiver.

107.2 Benefits and Limitations

The following table lists the services covered by each type of waiver:

Waiver	***Services Covered***
Elderly and Disabled Waiver	Case Management Services Homemaker Services Personal Care Services Adult Day Health Services Respite Care Services (Skilled and Unskilled) Companion Services Home Delivered Meals (Frozen Shelf-Stable and Breakfast Meals)
SAIL Waiver	Case Management Services Personal Care Services Environmental Accessibility Adaptations Personal Emergency Response System (PERS) Initial Setup Personal Emergency Response System (PERS) Monthly Medical Supplies Minor Assistive Technology Assistive Technology Evaluation for Assisted Technology Assistive Technology Repairs Personal Assistance Services

Waiver	*Services Covered*
Home- and community-based services for MR waiver	Residential Habilitation Training Residential Habilitation-Other Living Arrangement Day Habilitation-(Levels 1-4) Day Habilitation w/transportation-(Levels 1-4) Prevocational Services Supported Employment Occupational Therapy Services Speech and Language Therapy Physical Therapy Behavior Therapy-(Levels 1-3) Companion Services In-Home Respite Care Out-of-Home Respite Care Institutional Respite Personal Care Personal Care on Worksite Personal Care Transportation Environmental Accessibility Adaptations Specialized Medical Equipment and Supplies Skilled Nursing(RN/LPN) Assistive Technology Crisis Intervention Community Specialist
Home and community-based services for Living at Home Waiver	In-home Residential Habilitation Day Habilitation-(Levels 1-4) Day Habilitation w/transportation-(Levels 1-4) Supported Employment Prevocational Services In-Home Respite Out-of-Home Respite Personal Care Personal Care on Worksite Personal Care Transportation Physical Therapy Occupational Therapy Speech Therapy Behavior Therapy-(Levels 1-3) Skilled Nursing Environmental Accessibility Adaptations Specialized Medical Equipment and Supplies Community Specialist Crisis Intervention
Home and community-based services for Technology Assisted (TA) Waiver for Adults	Private Duty Nursing (RN/LPN) Personal Care/Attendant Service Medial Supplies and Appliances Assistive Technology
Home and community-based services for HIV/AIDS Waiver	Case Management Services Homemaker Services Personal Care Services Respite Care Services (Skilled and Unskilled) Skilled Nursing Services Companion Services

107.2.1 Financial Eligibility

Financial eligibility for the E&D waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Individuals receiving State or Federal Adoption Subsidy
- Optional categorically needy individuals at a special income level of 300 percent of the Federal Benefit Rate (FBR) who are receiving HCBS waiver services.

Financial eligibility for the MR waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate

Financial eligibility for the SAIL waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate

Financial eligibility for the Living at Home Waiver is limited to the following individuals:

- Individuals receiving SSI
- Medicaid for Low Income Families (MLIF)
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State or Federal Adoption Subsidy

Added: the

Added: Medicaid for Low Income Families (MLIF)

Added: SSI related protected groups deemed to be eligible for SSI/Medicaid

Added: Individuals receiving State or Federal Adoption Subsidy

Financial eligibility for Technology Assisted Waiver for Adults and the HIV/AIDS Waiver is limited to the following individuals:

- Individuals receiving SSI
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate
- State Supplementation
- Individuals eligible for the Pickle Program (continued Medicaid)
- Deemed disabled widow and widowers from age 50 but not yet age 60
- Early widow and widowers age 60-64
- Disabled adult children who lose Supplemental Security Income benefits upon entitlement to or an increase in the child's insurance benefits based on disability

- Individuals who would be eligible for SSI if not for deeming of income of parent(s) or a spouse
- Medicaid for Low Income Families (MILF)

Financial determinations are made by the Alabama Medicaid Agency, or the Social Security Administration (SSA), as appropriate. In addition to the financial and medical eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.2 Medical Eligibility

Medical eligibility criteria for the E&D,TA Waiver for Adult and HIV/AIDS Waivers are based on current admission criteria for nursing facility care. Admission criteria are described in Chapter 26 of the non-state Provider Manual, Nursing Facility.

The target groups for SAIL Waiver Services must meet the admission criteria for a nursing facility. The HCBS provider must specifically provide services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 60.

SAIL waiver services are provided, but not limited, to persons with the following diagnoses:

- Quadriplegia
- Traumatic brain injury
- Amyotrophic lateral sclerosis
- Multiple sclerosis
- Muscular dystrophy
- Spinal muscular atrophy
- Severe cerebral palsy
- Stroke
- Other substantial neurological impairments, severely debilitating diseases, or rare genetic diseases (such as Lesch-Nyhan Syndrome)

Eligibility criteria for HCBS for MR and LHW recipients are the same as eligibility criteria for an ICF-MR facility. MR and LHW persons who meet categorical medical and/or social requirements for Title XIX coverage will be eligible for HCBS under the waiver. Applicants found eligible are not required to apply income above the personal needs allowance reserved to institutional recipients toward payment of care. In addition to the financial and medical eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.3 Limitations

Medicaid does not provide waiver services to recipients in a hospital or nursing facility. However, case management activities are available to assist recipients interested in transitioning from an institution into a community setting under the SAIL and HIV/AIDS waivers. SAIL and HIV/AIDS case

management activities to facilitate the transition are limited to a maximum of 180 days prior to discharge into the community.

Medicaid or its operating agencies may deny home and community-based services if it determines that an individual's health and safety is at risk in the community; if the individual does not cooperate with a provider in the provision of services; or if an individual does not meets the goals and objectives of being on the waiver program.

NOTE:

SAIL waiver recipients must be age 18 years or older. LHW & MR waiver recipients must be age 3 years or older. TA waiver recipients must be age 21 or older and must have received private duty nursing services through the EPSDT Program under the Alabama Medicaid State Plan. HIV/AIDS Waiver recipients must be age 21 or older.

107.2.4 Explanation of Covered Services

This section describes the covered services available through the HCBS Waiver Program. Please note that descriptions for services may differ from program to program.

Adult Day Health Services (S5102/Modifier UA - E&D)

Adult Day Health Service provides social and health care for a minimum of 4 hours per day in a community facility approved to provide such care. Adult Day Health Service includes health education, self-care training, therapeutic activities, and health screening.

Adult Day Health is provided by facilities that meet the minimum standards for Adult Day Health Centers as described in the HCBS Waiver for the Elderly and Disabled. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

A unit is defined as a per diem rate.

Homemaker Services (S5130/Modifier UA - E&D) (S5130/Modifier U6 – HIV/AIDS)

Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning and personal services. Provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or is unable to manage the home and care for himself.

A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

A unit is defined as 15 minutes.

Case Management Services (T1016/Modifier UA - E&D) (T1016/Modifier UB - SAIL) (T1016/Modifier U6-HIV/AIDS)

Case management is a system under which a designated person or organization is responsible for locating, coordinating, and monitoring a group of services. A case manager is responsible for outreach, intake and referral, diagnosis and evaluation, assessment, care plan development, and implementing and tracking services to an individual. The case manager is also responsible for authorization of waiver services, terminations, and transfers and maintenance of recipient records.

Case management is provided by a case manager employed by or under contract with the state agencies as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

Case management activities under the SAIL & HIV/AIDS Waiver may also be used to assist individuals residing at least 90 days in institutional settings, such as hospital and nursing facilities, to transition into community settings. Transitional case management services may be provided up to 180 days prior to discharge from an institution.

A unit is defined as 15 minutes.

Personal Care Services (T1019/Modifier UA - E&D) (T1019/Modifier U6 – HIV/AIDS)

Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

A person providing personal care services must be employed by a certified Home Health Agency or other agency approved by the Alabama Medicaid Agency and supervised by a registered nurse, and meet the qualifications of a Personal Care Attendant as specified in the approved waiver document. This service cannot be provided by a family member.

A unit is defined as 15 minutes.

Personal Care Services (T1019/Modifier UB - SAIL)

Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

This person may be a relative or a friend of the relative when documentation shows that a relative or friend is qualified and there is proof of a lack of other qualified providers in a remote area.

A unit is defined as 15 minutes.

Respite Care (T1005/Modifier UA - E&D)
(T1005/Modifier U6 - HIV/AIDS)
Respite Care Unskilled (S5150/Modifier UA - E&D)
(S5150/Modifier U6 - HIV/AIDS)

Respite care is given to individuals unable to care for themselves on a short-term basis due to the absence or the need for relief of those persons normally providing the care. Respite care is provided in the individual's home and includes supervision, companionship and personal care of the individual.

Respite care may be provided for up to a maximum of 720 hours per waiver year. Respite care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN or RN, depending upon the care needs of the individual; this service cannot be provided by a family member.

A unit is defined as 15 minutes. The maximum number of units that can be billed is 2,880 per waiver year.

Companion Services (S5135/Modifier UA - E&D)
S5135/Modifier U6 – HIV/AIDS)

Companion services provide support and supervision that is focused on safety and non-medical care such as the following:

- Reminding recipient to bathe, to take care of personal grooming and hygiene, and to take medication
- Observing or supervision of snack and meal planning
- Accompanying recipient to necessary medical appointments and grocery shopping
- Assisting with laundry and light housekeeping duties that are essential to the care of the recipient.

Under no circumstances should any type of skilled medical service be performed. Companion services are provided in accordance with a therapeutic goal and are not purely recreational in nature. A person providing companion services must meet the qualifications of a companion worker as specified in the approved waiver document.

A unit is defined as 15 minutes.

NOTE:

Companion services are only available to recipients who live alone, and may not exceed four hours daily.

Day Habilitation (T2020/ Modifier UC/HW— MR-Level 1)

(T2020/Modifier UC/TF-MR-Level 2)

(T2020/Modifier UC/TG-MR-Level 3)

(T2020/Modifier UC/HK-MR-Level 4)

(T2020/Modifier UC/HW/SE-MR-Level 1-w/transportation)

(T2020/Modifier UC/TF/SE-MR-Level 2-w/transportation)

(T2020/Modifier UC/TG/SE-MR-Level 3-w/transportation)

(T2020/Modifier UC/HK/SE-MR-Level 4-w/transportation)

(T2020/Modifier UD/HW - LHW - Level 1)

(T2020/Modifier UD/TF - LHW - Level 2)

(T2020/Modifier UD/TG - LHW - Level 3)

(T2020/Modifier UD/HK – LHW – Level 4)

(T2020/Modifier UD/HW/SE – LHW – Level 1-w/transportation)

(T2020/Modifier UD/TF/SE – LHW – Level 2-w/transportation)

Deleted: ~~UC~~

(T2020/Modifier UD/TG/SE- LHW – Level 3-w/transportation)

Added: UD

Deleted: ~~UC~~

(T2020/Modifier UD/HK/SE – LHW – Level 4-w/transportation)

Added: UD

Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home or facility in which the recipient resides.

Services are normally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care. Day Habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. If a recipient attends Day Habilitation for less than four (4) hours as a result of a physician visit, and the transportation and escort is provided by the Day Habilitation Program staff, reimbursement will be permitted.

Day Habilitation Training services are provided by a Habilitation Aide and supervised by a Qualified Mental Retardation Professional (QMRP) in coordination with the individual's plan of care. The Habilitation Aide will be required to complete the training requirements as outlined in the waiver document.

*****The level utilized for Day habilitation services in the LHW is determined by the individual's ICAP score.

The provider for Day Habilitation services can be reimbursed based on eight levels of services.

A unit is defined as a per diem rate.

Residential Habilitation Training (T2016/Modifier UC –MR)

Residential Habilitation Training provides intensive habilitation training including training in personal, social, community living, and basic life skills.

Staff may provide assistance and training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming, and cleanliness.

This service includes social and adaptive skill building activities such as the following:

- Expressive therapy, the prescribed use of art, music, drama, and movement to modify ineffective learning patterns, or influence changes in behavior
- Recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities

The rate paid to providers for this service includes the cost to transport individuals to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the State Plan are not available, accessible, or desirable due to the functional limitations of the recipient.

Residential Habilitation Training services may be delivered or supervised by a Qualified Mental Retardation Professional (QMRP) in accordance with the individual's plan of care. Residential Habilitation Training services can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QMRP.

A Habilitation Aide is required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/MR. Retraining will be conducted as needed, at least annually.

A unit is defined as a per diem rate.

Respite Care - In Home (S5150/Modifer UC - MR)
(S5150/Modifier UD - LHW)

Respite Care - Out-of-Home (T1005/Modifier UC –MR)
(T1005/Modifier UD LHW)
Respite Care – Institutional (T2044/Modifier UC-MR)

Respite care is given to individuals unable to care for themselves on a short term basis due to the absence or the need for relief of persons normally providing the care. Respite care may be provided in the recipient's home, place of residence, or a facility approved by the State which is not a private residence.

Respite care out of the home may be provided in a certified group home or ICF/MR. In addition, if the recipient is less than 21 years of age, respite care out of the home may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out of home respite, no additional Medicaid reimbursement will be made for other services in the institution.

This service cannot be provided by a family member.

A unit is defined as 15 minutes. For institutional respite, a unit is defined as a per diem rate.

Residential Habilitation - Other Living Arrangement (OLA)
(T2017/Modifier UC –MR)
(T2017/Modifier UD - LHW)

Residential Habilitation Training in other living arrangements is a service under which recipients reside in integrated living arrangements such as their own apartments or homes. The basic concept of this service is that for some individuals, learning to be independent is best accomplished by living independently.

These services are delivered in the context of routine day-to-day living rather than in isolated "training programs" that require the individual to transfer what is learned to more relevant applications. Habilitation may range from a situation where a staff member resides on the premises to those situations where the staff monitors recipients at periodic intervals.

The staff may provide assistance/training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming, and cleanliness.

This service includes social and adaptive skill building activities such as the following:

- Expressive therapy, the prescribed use of art, music, drama, and movement to modify ineffective learning patterns, or influence changes in behavior
- Recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities

Residential habilitation training services for individuals in other living arrangements may be delivered or supervised by a QMRP in accordance with the individual's plan of care. Residential habilitation training can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QMRP.

A Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/MR. Retraining will be conducted as needed, at least annually.

The rate paid to providers for this service includes the cost to transport individuals to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the State Plan are not available, accessible, or desirable due to the functional limitations of the recipient.

A unit is defined as 15 minutes.

Supported Employment (T2018/Modifier UC –MR)
(T2018/Modifier UD – LHW)

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment also includes activities needed to sustain paid employment by waiver recipients, including supervision and training.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed.

When supported employment services are provided at a work site in which persons with disabilities are employed, payment will be made only for the adaptations, supervision, and training required by waiver recipients as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business settings.

Supported employment services are not available to recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or Section 602 (16) and (17) of the Education of the Handicapped Act.

Routine transportation, as by van within a 15-mile radius, is included in the fee for these services. This does not preclude other arrangements such as transportation by family or public conveyance.

A unit is defined as a per diem rate.

Prevocational Services (T2014/Modifier UC –MR)
(T2014/Modifier UD – LHW)

Prevocational services are not available to recipients who are eligible for benefits under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Education of the Handicapped Act.

Prevocational services prepare an individual for paid or unpaid employment, but are not job task oriented. Prevocational services include teaching such concepts as compliance, task completion, attention, problem solving, and safety.

Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Waiver recipients are compensated at a rate of less than 50 percent of the minimum wage.

A unit is defined as a per diem rate.

Physical Therapy (97110/Modifier UC-MR) (97110/Modifier UD-LHW)

Physical therapy includes services that assist in determining an individual's level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs.

Such services preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living.

This service also helps with progressive disabilities through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.

Physical Therapists may also provide consultation and training to staff or caregivers (such as recipient's family or foster family). The Physical Therapist must meet all state licensure requirements and be designated as a regulated Physical Therapist by the national accreditation body.

A unit is defined as 15 minutes.

Occupational Therapy Services (97535/Modifier UC –MR) (97535/Modifier UD – LHW)

Occupational therapy services include the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure or obtain necessary function.

Therapists may also provide consultation and training to staff or caregivers (such as recipient's family or foster family). The Occupational Therapist must meet all state licensure requirements and be designated as a regulated Occupational Therapist by the national accreditation body.

A unit is defined as 15 minutes.

Speech and Language Therapy (92507/Modifier UC –MR) (92507/Modifier UD – LHW)

Speech and language therapy services include screening and evaluation of individuals with speech and hearing impairments. Comprehensive speech and language therapy is prescribed when indicated by screening results.

This service provides treatment for individuals who require speech improvement and speech education. These are specialized programs designed for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.

Therapists may also provide training to staff and caregivers (such as a recipient's family and/or foster family). The Speech/Language Therapist must meet all state licensure requirements.

A unit is defined as 15 minutes.

Personal Emergency Response System (PERS)
(S5160/Modifier UB - Installation - SAIL)
(S5161/Modifier UB – Monthly - SAIL)

PERS is an electronic device that enables certain high-risk patients to secure help in the event of an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a "help" button is activated. Prior authorization is required for S5160.

A unit is defined as a monthly rate.

Personal Care (T1019/Modifier UC –MR) (T1019/Modifier UC/HW – MR)
(T1019/Modifier UD – LHW) (T1019/Modifier UD/HW-LHW)

Personal care services are services provided to assist residents with activities of daily living such as eating, bathing, dressing, personal hygiene, and activities of daily living. Services may include assistance with preparation of meals, but not the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting, and vacuuming, which are essential to the health and welfare of the recipient.

While in general personal care will not be approved for a person living in a group home or other residential setting, under the MR Waiver and LHW, personal care may be approved by the Division of Mental Retardation for specific purposes that are not duplicative.

Effective October 1, 2006, personal care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There will be a separate procedure code for this service, provided at the worksite, to distinguish it from other personal care activities.

The personal care attendant will work under the supervision of a QMRP and will be observed every 90 days. The personal care attendant is also required to complete the training requirements prior to providing services.

A unit is defined as 15 minutes.

Personal Care Transportation (T2001/Modifier UD – LHW)
(T2001/Modifier UC – MR)

Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of the personal care service. In order for this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. The Personal Care Transportation service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported.

The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer.

Personal Care Transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost-effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

A unit is defined as a mileage rate.

Companion Services (S5135/Modifier UC –MR)

Companion services are non-medical supervision and socialization provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation and shopping, but may not perform these activities as discrete services.

The provision of companion services does not entail hands-on medical care.

Companions may perform light housekeeping tasks that are incidental to the care and supervision of the recipient.

This service is provided in accordance with a therapeutic goal in the plan of care and is not merely recreational in nature. This service must be necessary to prevent institutionalization of the recipient.

The person providing companion service must meet the qualifications of a companion worker as specified in the waiver document. They also must have completed all training requirements.

A unit is defined as 15 minutes.

Behavior Therapy
(H2019/Modifier UC/HP - MR - Level 1)

(H2019/Modifier UC/HN – MR- Level 2)

(H2019/Modifier UC/HM – MR-Level 3)

(H2019/Modifier UD/HP – LHW – Level 1)

(H2019/Modifier UD/HN – LHW – Level 2)

(H2019/Modifier UD/HM – LHW – Level 3)

Behavior Therapy Service provides systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self direction or community integration, whose health is at risk and/or who may otherwise require movement to a more restrictive environment. Behavior therapy may include consultation provided to families, other caretakers and habilitation service providers. Behavior therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried and its continued use must be reviewed and re-justified every thirty days.

The Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to the supervision requirements described under provider qualifications.

The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

The maximum units of service per year of both professional and technician level units combined cannot exceed 600 and the maximum units of service of professional level cannot exceed 400.

Providers of service must maintain a service log that documents specific days on which services are delivered. Group therapy will not be reimbursed.

Providers at Level 1 must have either a Ph.D. or M.A. and be certified as a Behavior Analyst by the Behavior Analysis Certification Board.

Providers at level 2 must have either a Ph.D. or M.A. in the area of Behavior Analysis, Psychology, Special Education or a related field and three years of experience working with persons with developmental disabilities. Level 2 providers with a doctorate do not require supervision and may provide all of the service functions. Master's degreed individuals require supervision equaling two hours per week by a level 1 provider or level two Ph.D. provider may provide all of the service functions. Level 3 providers must be either a QMRP (per the standard at 43 CFR 483.430) or be a Board Certified Associate Behavior Analyst and work only in the technical service area. With two years experience and authorization by the Administering Agency, the Board Certified Behavior Analyst Associate may qualify as a level 2 provider and work in both the service component areas(professional and technical) with supervision.

All level 1 and 2 providers, certified or not, must complete an orientation training provided by DMH/MR.

A unit is defined as 15 minutes.

Environmental Accessibility Adaptations (S5165/Modifier UB – SAIL)
(S5165/Modifier UC –MR)
(S5165/Modifier UD – LHW)

Environmental modifications are those physical adaptations to the home, required by the recipient's plan of care, that are necessary to ensure the health, welfare and safety of the individual or enable the individual to function with greater independence in the home. This service must be necessary to prevent institutionalization of the recipient.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient.

Environmental Modifications exclude adaptations or improvements to the home that are not of direct medical or remedial benefit to the waiver recipient, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add square footage to the home are also excluded from this Medicaid-reimbursed benefit. All services provided must comply with applicable state or local building codes. This service requires prior authorization.

Total costs of environmental accessibility adaptations under the LHW shall not exceed $5,000 per year, per individual.

Under the SAIL Waiver the maximum amount for this service is $5,000 per recipient for the entire stay on the waiver. Any expenditure in excess of $5000 must be approved by the State Coordinator and the Medicaid designated personnel. This service may also be provided under the SAIL Waiver to assist an individual to transition from an institutional level of care to SAIL. The modifications should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver expenditures. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

A unit is defined as a per diem rate.

Specialized Medical Equipment
(T2029/Modifier UD - LHW)

This service includes medical equipment and supplies that are not covered in the Medicaid State Plan. The medical equipment or supplies must be included in the recipient's plan of care, and they must be necessary to maintain the recipient's ability to remain in the home. This service must be necessary to avoid institutionalization of the recipient. Invoices for medical equipment and supplies must be maintained in the case record. Medicaid reimbursement for this service under the LHW is limited to $5,000 per client, per waiver year.

Providers of this service must meet the same standards required for the providers under Alabama’s State Plan.

A unit is defined as a per diem.

Specialized Medical Equipment and Supplies
(T2028/Modifier UC-MR)

Specialized medical equipment and supplies to include devices, controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment and supplies not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefits to the recipient. All items shall meet applicable standards of manufacture, design and installation. Costs are limited to $5,000 per year, per individual.

Assistive Technology (T2029/Modifier UB – SAIL)
(T2029/Modifier UC MR)
(T2029/Modifier U5 - TA Waiver for Adults)

Assistive technology includes devices, pieces of equipment, or products that are modified or customized and are used to increase, maintain or improve functional capabilities of individuals with disabilities.

Assistive technology services also include any service that directly assists a disabled individual in the selection, acquisition, or use of an assistive technology device, including evaluation of need, acquisition, selection, design, fitting, customization, adaptation, and application. Items reimbursed with waiver funds are in addition to any medical equipment furnished under the State Plan and exclude those items which are not of direct medical or remedial benefit to the recipient. This service must be necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL Waiver. All items shall meet applicable standards of manufacture, design and installation. This service requires prior authorization.

The amount for this service under the TA Waiver for Adults is $20,000 per client. Any expenditure in excess of $20,000 must be approved by the Medicaid Agency. All assistive technology items on the TA Waiver for Adults require prior authorization.

The amount for this service under the SAIL Waiver is $15,000.00 per waiver recipient for the entire stay on the waiver. Any expenditure in excess of $15,000.00 must be approved by the state coordinator and the designated Medicaid personnel.

A unit is defined as a per diem rate.

Skilled Nursing (S9123/Modifier UC–RN; S9124/Modifier UC- LPN - MR)
(S9123/Modifier UD - LHW)
(S9123/Modifier U6 – HIV/AIDS)

Skilled nursing services are services listed in the plan of care that are within the scope of the Alabama Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. This service must be necessary to prevent institutionalization of the recipient.

A unit is defined as 1 hour.

Medical Supplies (T2028/Modifier UB – SAIL)

Medical supplies are necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

These medical supplies will only be provided when authorized by the recipient's physician and shall meet applicable standards of manufacture, design and installation. Providers of this service will be those who have a signed provider agreement with Medicaid and the Department of Rehabilitation Services. Medical supplies are limited to $1800.00 per recipient per year. The OA must maintain documentation of items purchased for the recipient.

A unit is defined as a per diem rate.

Evaluation for Assistive Technology (T2025/Modifier UB - SAIL)

This service will provide for an evaluation and determination of the client's need for assistive technology. The evaluation must be physician-prescribed and be provided by a physical therapist licensed to do business in the state of Alabama who is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS).

When applicable, a written copy of the physical therapist's evaluation must accompany the prior authorization request, and a copy must be kept in the recipient's file. This service must be listed on the recipients plan of care before being provided. Reimbursement for this service will be the standard cost per evaluation, as determined by Alabama Medicaid and ADRS. This service must be necessary to prevent institutionalization of the recipient.

This service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

A unit is defined as a per diem rate.

Assistive Technology Repairs (T2035/Modifier UB - SAIL)

This service will provide for the repair of devices, equipment or products that were previously purchased for the recipient. The repair may include fixing the equipment or devices, or replacement of parts or batteries to allow the equipment to operate. This service is necessary to ensure health and safety and prevent institutionalization. All items must meet applicable standards of manufacture, design and installation. Repairs must be arranged by the case manager and documented in the plan of care and case narrative. Prior authorization is not required for this service. Reimbursement for repairs shall be limited to $2,000 annually per recipient. Repair total must not exceed the amount originally paid for the equipment or device.

A unit is defined as a per diem rate.

Minor Assistive Technology (T2028 UB SC- SAIL)

Minor Assistive Technology (MAT) includes supplies, devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. MAT is necessary to maintain the recipient’s health, safety, and welfare and to prevent further deterioration of a condition and does not include common over the counter personal care items.

Minor Assistive Technology is limited to $500.00 per recipient per year. The OA must maintain documentation of items purchased for the recipient. Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency and the Department of Rehabilitation Services.

Vendors providing MAT/devices should be capable of supplying and training in the use of the minor assistive technology/device.

A unit is defined as a daily rate.

Waiver Frozen Meals (S5170/Modifier UA - E & D)
Waiver Shelf-Stable Meals (S5170/Modifier SC - E & D)
Breakfast Meals (S5170 - E & D)

Home Delivered meals are provided to an individual age 21 or older who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home delivered meals.

This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability dependency, who require nutritional assistance to remain in the community and do not have a caregiver available to prepare a meal for them. Meals provided by this service will not constitute a full daily nutritional regimen.

This service will be provided as specified in the plan of care, which may include: seven (7) or fourteen (14) frozen meals per week. In addition to frozen meals, the service may include the provisions of two (2) or more shelf-stable meals (not to exceed six meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's care plan.

In the event of an expected storm or disaster, the Meals Coordinator will authorize an approved Disaster Meal Service Plan.

A unit is defined as:

Seven-(7) pack of frozen meals equal to 1 unit.

Two (2) shelf-stable meals equal to 1 unit.

Seven-(7) pack of breakfast meals equal to 1 unit.

Personal Assistance Services (S5125/Modifier UB – SAIL)

Personal Assistant Services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual, if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities on or off the job.

This service will support that population with physical disabilities who are seeking competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community, which employs an individual with disabilities and there is interaction with non-disabled individuals who are in the same employment setting.

This service must be sufficient in amount, duration, and scope such that an individual with a moderate to severe level of disability would be able to obtain the support needed to both live and get to and from work.

A unit is defined as 15 minutes.

Personal Care/Attendant Service (T1019/Modifier U5 – TA Waiver for Adults)

Personal Care/Attendant Service (PC/AS) provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintaining continence, medication management and other activities of daily living (ALDs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

PC/AS is designed to increase an individual's independence and ability to perform daily activities and to support individuals with physical disabilities in need of these services as well as those seeking or maintaining competitive employment either in the home or an integrated work setting.

A unit is defined as 15 minutes.

Medical Supplies and Appliances (T2028/Modifier U5 – TA Waiver for Adults)

This service includes medical equipment and supplies that are not covered in the Medicaid State Plan. The medical equipment or supplies must be included in the recipient's plan of care, and they must be necessary to maintain the recipient's ability to remain in the home. This service must be necessary to avoid institutionalization of the recipient. Invoices for medical equipment and supplies must be maintained in the case record. Medicaid reimbursement for this service under the TA waiver is limited to $1,800 per client, per waiver year. An additional amount above that of $1,800 may be requested by the client and prior approved by Medicaid if medically necessary.

A unit is defined as a per diem rate.

Private Duty Nursing (S9123/Modifier U5 – RN; S9124/Modifier U5 – LPN - TA Waiver for Adults)

The Private Duty Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and Alabama State Board of Nursing. Private Duty Nursing under the waiver will not duplicate Skilled Nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Private Duty Nursing under the waiver is utilized. The objective of the Private Duty Nursing Service is to provide skilled medical monitoring, direct care, and intervention for individuals 21 and over to maintain him/her through home support. This service is necessary to avoid institutionalization and the individual must meet criteria outlined in the approved waiver document prior to receipt of services.

A unit is defined as 1 hour.

Community Specialist (H2015-UD – LHW)

(H2015-UC – MR)

Community Specialist Services include professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not. The service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports.

Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management.

A unit of service is defined as 15 minutes.

Crisis Intervention (H2011–UD - LHW)

(H2011-UC - MR)

Crisis Invention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual's removal from his current living arrangement.

When need for this service arises, the service will be added to the plan of care for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All crisis intervention services shall be approved by the regional community service office of the DMH/MR prior to the service being initiated.

Deleted: ~~$22,000~~

Added: $25, 000

Crisis intervention services will not count against the $25,000 per person per year cap in the waivers, since the need for the service cannot accurately be predicted and planned for ahead of time.

A unit of service is defined as 15 minutes.

107.2.5 Characteristics of Persons Requiring ICF-MR Level of Care Through the MR Waiver(formerly MR/DD) and Living at Home Waiver

Services provided in an intermediate care facility for the mentally retarded in Alabama are those services that provide a setting appropriate for a functionally mentally retarded person in the least restrictive productive environment currently available.

Generally, persons eligible for the ICF-MR level of care provided through the MR and LH Waiver need such a level of care because the severe, chronic nature of their mental impairment results in substantial functional limitations in three (3) or more of the following areas of life activity:

- Self Care
- Receptive and expressive language
- Learning
- Self-direction
- Capacity for independent living
- Mobility

ICF-MR care requires the skills of a QMRP to provide directly or supervise others in the provision of services. ICF-MR services address the functional deficiencies of the beneficiary to allow the beneficiary to experience personal hygiene, participate in daily living activities appropriate to his functioning level, take medication under appropriate supervision (if needed), receive therapy, receive training toward more independent functioning, and experience stabilization as a result of being in the least restrictive, productive environment that promotes the individual's developmental process.

Determining Eligibility for MR and LH Waiver

Determination regarding eligibility for care under the MR & LH Waiver is made by a Qualified Mental Retardation Professional (QMRP). An interdisciplinary team (described below) recommends continued stay. The recommendation is certified by a QMRP and a physician.

Qualifications of Interdisciplinary Review Team

An interdisciplinary team consisting of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, recommends continued stay.

The nurse will be a graduate of a licensed school of nursing with a current state certification as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). This person will have knowledge and training in the area of mental retardation or related disabilities with a minimum of two years' experience.

The social worker will be a graduate of a four-year college with an emphasis in social work. This person will have knowledge and training in the area of mental retardation or related disabilities with a minimum of two years' experience.

The psychologist will possess a Ph.D. in Psychology. This person will be a licensed psychologist with general knowledge of test instruments used with the mentally retarded or related disabilities with a minimum of two years' experience.

Other professional disciplines may be represented on the assessment team as necessary depending on the age, functional level, and physical disability of the recipients:

- Special Education
- Speech Pathologist
- Audiologist
- Physical Therapist
- Optometrist
- Occupational Therapist
- Vocational Therapist
- Recreational Specialist
- Pharmacist
- Doctor of Medicine
- Psychiatrist
- Other skilled health professionals

Individual Assessments

Medicaid requires an individual plan of care for each MR & LH waiver service recipient. The Individual Habilitation Plan (IHP) is subject to review by Medicaid and CMS.

The DMH/MR (or its contract service providers) use assessment procedures to screen recipients for eligibility for the Waiver services as an alternative to institutionalization. Assessment procedures are based on eligibility criteria for ICF-MR developed jointly by DMH/MR and Medicaid.

Review for "medical assistance" eligibility may be performed by a qualified practitioner in the DMH/MR, by its contract service providers, or by qualified (Diagnostic and Evaluation Team) personnel of the individual or agency arranging the service.

Recipients are re-evaluated on an annual basis. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and CMS.

A written assessment is a method for determining a recipient’s current long-term care needs. This comprehensive instrument is used to access each individual recipient’s functional, medical, social, environmental, and behavioral status. Information obtained should be adequate enough to make a level of care decision and for case managers to develop an initial plan of care.

Re-evaluations are done on an annual basis or when needed. Written documentation of all assessments is maintained in the recipient’s case file and is subject to review by Medicaid and CMS.

107.2.6 Informing Beneficiaries of Choice

Medicaid is responsible for ensuring that beneficiaries of the waiver service program are advised of feasible service alternatives and receive a choice regarding which type of service they wish to receive (institutional or home- and/or community-based services).

Medicaid advises applicants for NF, ICF, ICF-MR services, or their designated responsible party, of feasible alternatives to institutionalization at the time of their entry into the waiver system. All applicants found eligible will be offered the alternative unless there is reasonable expectation that the services required would cost more than institutional care.

When residents of long-term care facilities become eligible for home and community-based services under this waiver, the resident will be advised of the available services and given a choice of service providers.

107.2.7 Cost for Services

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

Deleted: ~~$22,000~~
Added: $25, 000

The cost for services to individuals who qualify for home and community-based care under the LAH waiver program will not exceed a cap of $25,000 per client per year with the exception that crisis intervention services are not included in the cap.

107.2.8 Records Used for Medicaid Audits

Providers must maintain financial accountability for funds expended on HCBS and provide a clearly defined audit trail.

Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients for a three-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the state of Alabama, the provider will pay the travel cost of the auditors.

The state agencies as specified in the approved waiver document as operating agencies of home and community-based services, will have their records audited at least annually at the discretion of the Alabama Medicaid Agency. Payments for services are adjusted to actual cost at the end of each waiver year.

The Alabama Medicaid Agency will review at least annually the recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

The state agencies as specified in the approved waiver document provide documentation of actual costs of services and administration. The Quarterly Cost Report includes all actual costs incurred by the operating agency for the previous quarter and include costs incurred for the current year-to-date. The state agencies submit this document to Medicaid before the first day of the third month of the next quarter.

Failure to submit the actual cost documentation can result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed.

The providers of the HCBS waivers will have their records audited at least annually at the discretion of Medicaid. Medicaid will recover payments that exceed actual allowable cost.

Medicaid reviews recipients' habilitation and care plans and services rendered by a sampling procedure. The review includes appropriateness of care and proper billing procedures.

Providers of the HCBS waivers are required to file a complete uniform cost report of actual statistics and costs incurred during the entire preceding year. The cost reports for E&D and MR must be received by Medicaid on or before December 31. Cost reports for the SAIL Waiver must be received on or before June 1. Extension may be granted only upon written request. If a complete cost report is not filed by the due date or an extension is not granted, a penalty of $100 per day for each day past the due date will be imposed on the provider. The penalty will not be a reimbursable Medicaid cost. For detailed information on penalties see MR Waiver Fiscal Procedures Manual. Providers of the LHW, TA Waiver for Adults, and HIV/AIDS Waiver are not required to submit uniform cost reports. The method of payment is on a fee-for-service basis.

Quarters for MR and E&D are defined as follows:

Quarter	*Reporting Period*	*Due Date*
1st	October – December	Due before March 1
2nd	January – March	Due before June 1
3rd	April – June	Due before September 1
4th	July – September	Due before December 1

Quarters for SAIL are defined as follows:

Quarter	*Reporting Period*	*Due Date*
1st	January – March	Due before June 1
2nd	April – June	Due before September 1
3rd	July – September	Due before December 1
4th	October – December	Due before March 1

107.2.9 HCBS Payment Procedures

Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a procedure code. Respite care will have one code for skilled and another for unskilled.

The basis for the fees are usually based on audited past performance with consideration given to the health care index and renegotiated contracts. The interim fees may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however, no single claim can cover services performed in different months. For example, 10/15/02 to 11/15/02 would not be allowed. If the submitted claim covers dates of service part or all of which were covered in a previously paid claim, the claim will be rejected.

Payment will be based on the number of units of service reported on the claim for each procedure code.

The Operating Agencies (OA), as specified in the approved waiver document are governmental agencies and will receive actual cost for services rendered. The actual fee for service may differ among OAs.

Accounting for actual cost and units of services provided during a waiver year must be captured on CMS Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

- A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document.
- An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-case payments, such as depreciation, occur when transactions are recorded by the state agency.
- The services provided by an operating agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

The provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the fee for service. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since Administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.

The Alabama Medicaid Agency's Provider Audit/Reimbursement Division maintains the year-end cost reports submitted by the Alabama Department of Public Health (ADPH) and the Alabama Department of Senior Services (ADSS).

Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a six (6) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The OA, Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

NOTE:

The operating agencies are governmental; therefore, the interim rates for services must be adjusted to cost and the claims for services provided during that year must be reprocessed to adjust payments to the actual cost incurred by each operating agency. The rates for each service for each operating agency may differ. For the E&D waiver, operating agencies have 120 days from the end of a waiver year to file their claims. The operating agencies for MR, and SAIL waivers have 180 days from the end of a waiver year to file. Since the actual cost incurred by each operating agency sets a ceiling on the amount it can receive, no claims for the dates of service within that year will be processed after the adjustment is made. For the LHW and the HIV/AIDS Waiver, the operating agency must file all claims for services within 12 months from the date of service. For the TA Waiver for Adults, the providers must file all claims for services rendered within 12 months from the date of service provision.

107.2.10 Records for Quality Assurance Audits

The operating agencies for the E&D, MR, LH and HIV/AIDS waivers are required to maintain all records pertaining to the waiver recipients. They should also maintain the following information for audit purposes:

- Daily activity logs
- Narratives
- Evaluations and reevaluations
- Complaints and grievances
- Billing and payment records
- Plan of Care
- Delivery of services
- Any other important tools used to determine the success of the waiver services

This information is used to ensure that the state is in accordance with the approved waiver document and services are appropriate for the individual being served.

This information shall be made available to Medicaid and any other party in the contractual agreement at no cost.

NOTE:

Records for Quality Assurance audits for the TA Waiver for Adults conducted by the in-house Medicaid Reviewer will be maintained at the Alabama Medicaid Agency.

107.2.11 Appeal Procedure (Fiscal Audit)

Medicaid conducts fiscal audits of all services. At the completion of a field audit there will be an exit conference with the provider to explain the audit findings. The provider will have the opportunity agree or disagree with the findings.

Medicaid reviews the field audit and provider comments and prepares a letter to make the appropriate findings official. If the provider feels that some of the findings are not justified, the provider may request an informal conference with Medicaid. To request the informal conference, the provider must submit a letter within 30 days of the date of the official audit letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Provider Audit Division, Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624.

Medicaid forwards decisions made as a result of the informal conference to the provider by letter. If the provider believes that the results of the informal conference are still adverse, the provider will have 15 days from the date of the letter to request a fair hearing.

Quality Assurance (QA) reviews are performed on an annual basis by Medicaid. At the end of this review there will be an exit conference with the providers to explain the findings. The provider will have an opportunity to agree or disagree.

Medicaid reviews the findings and prepares an official letter. If the provider feels that some of the findings are not justified, the provider may request an informal conference with Medicaid. To request the informal conference, the provider must submit a letter within 30 days of the date of the official review letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Quality Assurance Division, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.

If the provider is not satisfied with the findings of the informal conference, the provider may request a fair hearing.

107.3 Prior Authorization and Referral Requirements

Certain procedure codes for waivers require prior authorization. Refer to Section 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

Application Process

The case manager receives referrals from hospitals, nursing homes, physicians, the community, and others for persons who may be eligible for HCBS.

The plan of care, which is developed by the case manager and applicant's physician, is part of this assessment. The plan of care includes the following:

- Objectives
- Services
- Provider of services
- Frequency of services

The Alabama Medicaid Agency requires providers to submit an application in order to document dates of service provision to long term care recipients maintained by the long term care file. Application approvals will be done automatically through systematic programming. Quality Improvement and Standards Division will perform random audits on a percentage of records to ensure that documentation exists to support the medical level of care criteria, physician certification, as well as other state and federal requirements.

Case managers and/or designated staff of the HCBS waiver Operating Agency(ies) will assess the client to determine the risk for institutionalization and determine if the medical level of care is met according to Medicaid criteria.

Assessment data will be entered and submitted electronically through the use of the Alabama Medicaid Agency Interactive website . If problems are encountered such as mismatched Social Security Numbers and/or Medicaid numbers, date conflicts, invalid NPIs, or financial ineligibility, the auto-application will be denied and returned. Information will be provided to the user of the appropriate action(s) to take to correct the problem and will be allowed to resubmit the application.

The application, upon completion of processing, will systematically assign approval dates in one-year increments. For initial assessments, once the application is submitted with an indication of an initial assessment, the system will apply the begin date as the date of submission plus one year, which is extended to the last day of the month. For re-determinations, the application is submitted with an indication of a re-determination and the system will pick up the end date already on the file and extend for one year.

No charges for services rendered under the waiver program prior to the approval payment dates will be paid.

Application Process for TA Waiver for Adults

The Alabama Department of Rehabilitation Services (ADRS) targeted case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community based services.

An assessment document will be completed by the targeted case manager, in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the Alabama Medicaid Agency for approval.

The targeted case manager, in conjunction with the applicant's physician will develop a plan of care. The plan of care will include objectives, services, provider of services, and frequency of service. The plan of care must be submitted to the Alabama Medicaid Agency for approval. Changes to the original plan of care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's care

plan, which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the targeted case manager as often as necessary and administered in coordination with the recipient's physician.

The targeted case manager will coordinate completion of the medical need admissions form with the applicant's physician and the financial application form for submission to the Alabama Medicaid Agency's Long Term Care Policy Advisory Unit.

The LTC Policy Advisory Unit will submit the medical application to our Associate Medical Director for review to determine if the individual meets the criteria for nursing facility care, in accordance with Rule No 560-X-10-.10 of the Alabama Medicaid Administrative Code. The LTC Policy Advisory Unit will submit the "Waiver/Slot Confirmation Form" to the District Office for processing financial determination.

If approved, the applicant and the targeted case manager will be notified in writing.

If denied, the applicant and the targeted case manager will be notified and the reconsideration process will be explained in writing as described in Rule No. 560-X-10-.14 of the *Alabama Medicaid Administrative Code*.

When an application is approved by the Alabama Medicaid Agency, a payment date is also given for the level of care for which a recipient has been approved. No charges for services rendered under the Waiver Program prior to this approved payment date will be paid.

A current assessment document, along with a new plan of care, and medical need admission form must be submitted by the targeted case manager to the Alabama Medicaid Agency at each re-determination of eligibility which shall be at least every six (6) months.

Fair Hearings

An individual whose application to the waiver program is denied may request a hearing through the appropriate operating agency (the Alabama Department of Public Health (ADPH), the Alabama Department of Senior Services (ADSS), the Alabama Department of Rehabilitation Services (ADRS), or the Alabama Department of Mental Health/Mental Retardation (ADMH/MR)). An individual whose application to the TA Waiver for Adults is denied may request a fair hearing through the Alabama Medicaid Agency.

An individual who is denied HCBS may request a fair hearing in accordance with Chapter 3 of the *Alabama Medicaid Administrative Code*.

Applicants will be notified in writing within ten days of denial or termination of service.

- Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

A written request for a hearing must be filed within 60 days following notice of action for which an individual is dissatisfied.

107.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Waiver service providers.

107.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Waiver service providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted. TA Waiver for Adults providers must file claims on a UB-04 claim form when filing hard copy. Medicare-related claims must be filed using the Institutional/Medicare-related claim form for TA Waiver recipients.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

107.5.1 Time Limit for Filing Claims

The operating agencies for the E&D waiver have 120 days at the end of the waiver year to process claims. The operating agencies for the MR and SAIL waivers have 180 days at the end of the waiver year to process claims. Living at Home Waiver, Technology Assisted Waiver for Adults and the HIV/AIDS Waiver claims are to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

107.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

107.5.3 Procedure Codes

Deleted: ~~Diagnosis Codes (SAIL) section~~

The following procedure codes apply when filing claims for Elderly and Disabled Waiver services:

Code	*Description*	*PA Required?*
T1016-UA	Case Management	No
T1019-UA	Personal Care	No
S5102-UA	Adult Day Health	No
T1005-UA	Respite Care – Skilled— Billed per hour	No
S5150-UA	Respite Care – Unskilled	No
S5130-UA	Homemaker	No
S5135-UA	Companion	No
S5170-UA	Waiver Frozen Meals	No
S5170-SC	Waiver Shelf-Stable Meals	No
S5170	Waiver Breakfast Meals	No

The following procedure codes apply when filing claims for SAIL Waiver services. These services are limited to recipients age 18 and over.

Code	*Description*	*PA Required?*
T1016-UB	Case Management	No
T1019-UB	Personal Care Services	No
S5165-UB	Environmental Accessibility Adaptations	Yes
T2028-UB	Medical Supplies – (exempt from TPL)	No
T2028-UB & SC	Minor Assistive Technology	No
S5160-UB	Personal Emergency Response Systems/Initial (exempt from TPL)	Yes
S5161-UB	Personal Emergency Response Systems/Monthly Service Fee	No
T2029-UB	Assistive Technology	Yes
S5125-UB	Personal Assistance Services	No
T2025-UB	Evaluation for Assistive Technology	No
T2035-UB	Assistive Technology Repairs	No

The following procedure codes apply when filing claims for Mental Retardation services

Code	*Description*	*PA Required?*
T2020-UC & HW	Day Habilitation Services- Level 1	No
T2020-UC & TF	Day Habilitation Services-Level 2	No
T2020-UC & TG	Day Habilitation Services-Level 3	No
T2020-UC & HK	Day Habilitation Services-Level 4	No
T2020-UC & HW & SE	Day Habilitation Services w/ transportation- Level 1	No
T2020-UC & TF & SE	Day Habilitation Services w/transportation-Level 2	No

Code	*Description*	*PA Required?*
T2020-UC & TG & SE	Day Habilitation Services w/transportation-Level 3	No
T2020-UC & HK & SE	Day Habilitation Services w/transportation-Level 4	No
T2016-UC	Residential Services	No
S5150-UC	In-home Respite Care	No
T1005-UC	Out-of-Home Respite	No
T2044-UC	Institutional Respite	No
T2017-UC	Residential Services - Other Living Arrangements	No
T2018-UC	Supported Employment Services	No
T2014-UC	Prevocational Services	No
97110-UC	Physical Therapy	No
97535-UC	Occupational Therapy	No
92507-UC	Speech and language Therapy	No
T1019-UC	Personal Care	No
T1019-UC & HW	Personal Care on Worksite	No
T2001-UC	Personal Care Transportation	No
S5135-UC	Companion Services	No
H2019-UC & HP	Behavior Therapy-Level 1	No
H2019-UC & HN	Behavior Therapy-Level 2	No
H2019-UC & HM	Behavior Therapy-Level 3	No
S5165-UC	Environmental Accessibility Adaptations	No
T2029-UC	Assistive Technology	No
S9123-UC	Skilled Nursing-RN	No
S9124-UC	Skilled Nursing-LPN	No
T2028-UC	Specialized Medical Equipment & Supplies	No
H2015-UC	Community Specialist	No
H2011-UC	Crisis Intervention	No

The following procedure codes apply when filing claims for Living at Home Waiver services:

Code	**Description (All services exempt from TPL and MC)**	**PA Required?**
T2017-UD	In-Home Residential Habilitation	No
T2020-UD & HW	Day Habilitation (Level 1)	No
T2020-UD & TF	Day Habilitation (Level 2)	No
T2020-UD & TG	Day Habilitation (Level 3)	No
T2020-UD & HK	Day Habilitation (Level 4)	No
T2020-UD & HW & SE	Day Habilitations w/transportation – Level 1	No
T2020-UD & TF & SE	Day Habilitations w/transportation – Level 2	No
T2020-UD & TG & SE	Day Habilitations w/transportation - Level 3	No

Code	Description (All services exempt from TPL and MC)	PA Required?
T2020-UD & HK & SE	Day Habilitations w/transportation – Level 4	No
T2018-UD	Supported Employment	No
T2014-UD	Prevocational Services	No
S5150-UD	Respite In-Home	No
T1005-UD	Respite Out-of-Home	No
T1019-UD	Personal Care	No
T1019-UD & HW	Personal Care on Worksite	No
T2001-UD	Personal Care Transportation	No
97110-UD	Physical Therapy	No
97535-UD	Occupational Therapy	No
92507-UD	Speech Therapy	No
H2019-UD & HP	Behavior Therapy-Level 1	No
H2019-UD & HN	Behavior Therapy-Level 2	No
H2019-UD & HM	Behavior Therapy-Level 3	No
S9123-UD	Skilled Nursing	No
S5165-UD	Environmental Accessibility Adaptations	No
T2029-UD	Specialized Medical Equipment/Supplies	No
H2015-UD	Community Specialist	No
H2011-UD	Crisis Intervention	No

NOTE:

Effective for dates of service prior to January 1, 2007, all services for the LHW require prior authorization (PA). The PA number issued authorizes the service(s) to be provided, the length of time that the service(s) should be provided to the client, and the maximum units of each service that should be rendered to the individual as indicated in the authorized plan of care.

The following procedure codes apply when filing claims for TA Waiver for Adults services:

Code	*Description*	*PA Required?*
S9123-U5	Private Duty Nursing - RN	No
S9124-U5	Private Duty Nursing - LPN	No
T1019-U5	Personal Care/Attendant Service	No
T2028-U5	Medical Supplies and Appliances	No
T2029-U5	Assistive Technology	Yes

The following procedure codes apply when filing claims for HIV/AIDS Waiver services:

Code	*Description*	*PA Required?*

Code	*Description*	*PA Required?*
T1016-U6	Case Management Services	No
T1019-U6	Personal Care Services	No
T1005-U6	Respite Care Services – Skilled	No
S5150-U6	Respite Care Services - Unskilled	No
S5130-U6	Homemaker Services	No
S9123-U6	Skilled Nursing	No
S5135-U6	Companion Service	No

107.5.4 Place of Service Codes

The following place of service codes apply when filing claims for Waiver service:

POS Code	*Description*
12	Home (Residential) —MR Waiver, SAIL Waiver, LHW, TA Waiver for Adults, and the HIV/AIDS Waiver
21	Inpatient Hospital-SAIL Waiver and HIV/AIDS Waiver
31	Skilled Nursing Facility or Nursing Home-SAIL Waiver and HIV/AIDS Waiver
32	Nursing Facility-SAIL Waiver and HIV/AIDS Waiver
51	Inpatient Psychiatric Facility-SAIL Waiver and HIV/AIDS Waiver
54	Intermediate Care Facility/Mentally Retarded-SAIL Waiver and HIV/AIDS Waiver
99	Other Unlisted Facility —MR Waiver, Elderly & Disabled Waiver, LHW, TA Waiver for Adults, SAIL, HIV/AIDS

107.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

107.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Patient 1st	Chapter 39
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
UB92 Claim Filing Instructions	Section 5.3

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